New Jersey Department of Human Services
Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

CLIENT FUNDING UTILIZATION

	Name of Agency
Name of Client	Social Security Number
Street Address	
City, State, Zip Code	

A. Total Adjusted Income of Client (or Client and Spouse) $ _____

B. Per Diem Reimbursement by NJDHS Alzheimer's Adult Day Services $ _____

C. Co-Payment to be Assessed per Unit of Service $ _____

D. Alzheimer's Adult Day Services Funding Start or Renewal Date _____

E. Weekly Units (Days) to be Provided Through:

- Alzheimer's Adult Day Services _____
- Statewide Respite _____
- Medicaid _____
- MLTSS _____
- SSBG _____
- Older Americans Act _____
- Peer Grouping _____
- JACC _____
- Other Funding Source (Specify): _____ _____
- Pay Privately _____
- Total Weekly Units _____

I have agreed to the co-payment rate listed above.	
Signature of Primary Caregiver	Date
I have reviewed the payment plan with the client's caregiver.	
Name of Agency Representative	Title
Signature	Date

Distribution: White-NJDHS Copy-Agency